



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 20, 2015

Mr. William Spalding, Administrator
Pillsbury Manor - North
1530 Williston Road
South Burlington, VT 05403-6422

Dear Mr. Spalding:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 21, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota, RN".

Pamela M. Cota, RN
Licensing Chief

PC:jl

PRINTED: 02/02/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED: C 01/21/2015
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NAME OF PROVIDER OR SUPPLIER
PILLSBURY MANOR - NORTH
STREET ADDRESS, CITY, STATE, ZIP CODE
1530 WILLISTON ROAD
SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensure survey was conducted on 1/20/15 and 1/21/15 in conjunction with a complaint investigation. The following regulatory violations were identified related to the re-licensure survey. There were no findings related to the complaint.	R100	<i>POC</i> <i>In regards to Resident #1 - Further Care Planning has already been done to address the residents increased risk of falling and/or wandering between hours of 4pm and 6AM. A sign off sheet is in place for staff doing initial or standing night checks. If resident is up will offer to bring him to common area with supervisor. Offering food and drink. If falls continue will change to 6 hr checks. During hours checks falls. In addition companionship every day. (e.g. Pillsbury staff after noon meal will spend time through our (Pillsbury Pal program) to play cards, take a walk or watch TV. A 150+ residents seque was decreased</i>	2/12/15
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the home failed to develop and/or revise care plans to reflect the current status and needs of 2 of 6 residents reviewed. (Residents #1 and #4). Findings include: 1. Per record review Resident #1, who was admitted to the home on 12/20/11 and whose diagnoses included cognitive impairment and a movement disorder that can lead to difficulties walking, was identified as being at risk for wandering and falls. The resident's care plan, dated 2/23/12, indicated that s/he utilized a wheelchair or walker for ambulation and reflected the resident's risk for wandering and falls, including interventions, such as hourly safety checks at night, to decrease fall risk. However, despite the interventions in place progress notes revealed	R145		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8699

28XP11

TITLE *Administrator* (X6) DATE *2/12/15*
If continuation sheet of 8

R145 - R252 POCs accepted 2/12/15 Btwnen1pm

FEB 18 2015

PRINTED: 02/02/2015
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R100	Initial Comments: An unannounced on-site re-licensure survey was conducted on 1/20/15 and 1/21/15 in conjunction with a complaint investigation. The following regulatory violations were identified related to the re-licensure survey. There were no findings related to the complaint.	R100	<p>700</p> <p>In regards to Resident #1 - Further Care Planning has already been done to address the residents increased risk of falling and/or wandering between hours of 9PM and 6AM - A sign off sheet is in place for initial of staff doing hourly checks - If resident is up will offer to bring him to common area with supervision. Offering food and drink. If falls continue will change to 1/2 hr. checks. Walking hourly checks taken in addition to companionship every day - 6-9PM Pillsbury staff after noon meal will spend time through our (Pillsbury Fall Program) to play cards, take a walk or watch TV. Also - residents Seogue was decreased</p>	2/12/15
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the home failed to develop and/or revise care plans to reflect the current status and needs of 2 of 6 residents reviewed. (Residents #1 and #4). Findings include: 1. Per record review Resident #1, who was admitted to the home on 12/20/11 and whose diagnoses included cognitive impairment and a movement disorder that can lead to difficulties walking, was identified as being at risk for wandering and falls. The resident's care plan, dated 2/23/12, indicated that s/he utilized a wheelchair or walker for ambulation and reflected the resident's risk for wandering and falls, including interventions, such as hourly safety checks at night, to decrease fall risk. However, despite the interventions in place progress notes revealed	R145		

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R145	<p>Continued From page 1</p> <p>that the resident had sustained falls [requiring Emergency Room [ER] visits for evaluation on 2 of the occasions] on at least 5 occasions between 5/30/14 and 10/1/14. The progress notes also indicated the resident had been found wandering without use of wheelchair or walker both within and outside the home on multiple occasions over the past several months, including a note, on 9/13/14 which stated; "res found going down the stairwell backwards, dragging w/c down with [him/her]." Although the care plan was updated on both 10/28/14 and 12/31/14 the resident continued on the same night time hourly safety checks that were initiated on 12/23/12. No further interventions had been identified to assure the resident's safety from wandering and/or falls between the hours of 9:00 PM and 6:00 AM, which was when the resident had sustained all his/her falls between 5/30/14 and 10/1/14. In addition, and although the resident had again sustained falls on at least 4 more occasions between 10/26/14 and 1/20/15, all of which occurred between the hours of 9:00 PM and 11:00 PM, the care plan had still not been revised to address the need for increased supervision and monitoring during those high risk hours.</p> <p>Per interview, at 10:00 AM on the morning of 1/21/15, the LPN Nurse Manager confirmed that the resident was at risk for falls and wandering, and agreed there was a safety concern and a need for close supervision and monitoring. S/he stated that the home was no longer able to provide the level of care needed by the resident, the resident had been given a 30 day discharge notice on 11/7/14 and the family was attempting to find alternate placement that could provide higher level of care, but had, to date, been unsuccessful. The Nurse Manager also</p>	R145	<p>#1 cont'd. - on 8/07/14 + 9/1/14 which might have been contributing to falls during the time period noted 10/20 - 9/1/14 - but it should have been care planned going forward it will be. Some improvement was noted after change - again going forward all care planned. This will be ongoing as resident changes. Felicia Stinchfield LPN - Manager/ Admin. will be responsible. But above care planning done as of 2/12/15</p> <p><i>Debrah Lemery RN</i></p>	2/12/15

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R145	<p>Continued From page 2</p> <p>acknowledged that although the resident's falls had all occurred after 9:00 PM, the care plan did not address the increased risk of falls and need for closer supervision during those hours.</p> <p>2. Per record review although Resident #4 was identified with a skin lesion on his/her toe that required medical evaluation and treatment, the care plan did not address skin integrity issues. The resident, who was admitted on 7/30/13 had progress notes, dated 7/31/13 and 8/1/13, that indicated the resident's left great toe had an open "lesion about 2 cm x 2 cm long....uncomfortable at times..Protective drsg...applied..." The resident was seen by a Podiatrist on 8/7/13 who recommended interventions to treat and protect the area. Despite the evidence of an actual issue and risk for ongoing potential skin integrity concerns, the care plan did not address this issue. In addition the initial resident assessment, dated 8/13/13, identified the resident's cognitive status as moderately impaired and there was documentation that the resident exhibited daily wandering behaviors. The only intervention included on the resident's care plan, dated 8/14/13, stated; 'if increased wandering in hallway noted....during waking hours bring downstairs for socialization and diversion; if during noct, may implement Q1H checks'. Multiple progress notes between 9/24/13 and 1/7/14 revealed ongoing episodes of Resident #4 wandering into the rooms of other residents during all hours of the day and night, causing some residents to express anger and frustration at the intrusive behaviors. A note on 12/1/13 at 9:25 PM stated: 'Some wandering in halls after hs care. Another resident had requested his/her door be locked to keep [Resident #4] out of room.' A note on 1/7/14: 'res cont's to wander into other res room...making res upset. S/he states "every time I close my eyes</p>	R145	<p>POC. #2 Resident #4, now deceased, as of 1/15/14. Going forward on all residents, if there is a skin integrity issue of any kind will be care planned. All staff will be aware and family, M.D updated. With all residents it will be addressed on care plan with probable reason and all approaches documented with hopeful outcome and progress. If resolved will indicate but will continue to monitor due to previous compromise. The issue of wandering into others rooms being intrusive on any resident with that kind of concern will be care</p>	2/12/15

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R145	Continued From page 3 s/he wakes me up again." Despite this ongoing behavior by Resident #4 his/her care plan had not been revised to include interventions to prevent access to other resident rooms by Resident #4. The LPN Nurse Manager confirmed, during interview at 10:00 AM on the morning of 1/21/15, that the resident's care plan did not address the issues of skin integrity, nor revised to include interventions to prevent access to other resident rooms.	R145	<p>#2 cont'd -</p> <p>Planned. All staff made aware of approaches and desired outcome. Updated and changed as needed. Family will be made aware for possible need for companionship. If all approaches are unsuccessful - might be a conversation of alternate placement.</p> <p>Ongoing - Responsible Felicia Stinchfield LPN manager/ Admin.</p> <p>Deborah Offenbacher RW</p> <p>DOC - 2-2-07-3b</p> <p>a. g. b. - repair and painting will be completed by March 1, 2015 - by OER Maintenance Dept.</p>	2/6/15
R252 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the home failed to assure that areas used for storage of equipment and utensils were kept clean. Findings include: During a tour of the kitchen with the Chief Cook, at 2:00 PM on 1/20/15, the following observations were made: a. There was peeling paint with paint chips hanging from the kitchen ceiling area surrounding a light, located directly above open wire rack shelves on which newly cleaned dishware was stored. b. Several areas of the ceiling in the dish cleaning	R252		

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R252	<p>Continued From page 4</p> <p>and storage area of the kitchen had large water stains and peeling paint.</p> <p>c. The exhaust fan, located in the ceiling over the dish cleaning area was heavily coated with grease and dust debris was hanging from it.</p> <p>During interview, at the time of tour, the Chief Cook confirmed the above observations. S/he stated the water stains on the ceiling were the result of a leak that had occurred several months ago.</p>	R252	<p>c. The exhaust fan has been thoroughly cleaned and is now on a cleaning schedule</p> <p>- To be done on a regular basis - by the cook -</p> <p>Sean Rogers - will be responsible as Food Service Director -</p> <p>It is ongoing accountability & responsibility</p>	2/12/15